2013 WL 8214486 (Ill.App. 4 Dist.) (Appellate Brief)
Appellate Court of Illinois, Fourth District.

In Re the Matter: Mary SLEPICKA, by and through Joann Kaminski, her agent and Attorney-in-fact, Plaintiff-Appellant,

v.

STATE OF ILLINOIS, acting through the Illinois Department of Public Health and Teresa Garate, Ph.D., its Assistant Director, and Lamar Hasbrouck, MD, MPH, its Director, and Holy Family Villa, Defendant-Appellees.

No. 2012-1103.
April 26, 2013.

Appeal from the Circuit Court of the Seventh Judicial Circuit, Sangamon County, Illinois
Circuit No.: 2012-MR-743
The Honorable John Schmidt, Judge Presiding.
Oral Argument Reqested

Appellant's Reply Brief

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***1 1. No Brief by Agency.**

At the outset it must be noted that the Administrative agency has not filed a brief. It made no effort before the circuit court, and the Department makes no effort here to justify its decision, it leaves it to the facility to defend the decision. This is understandable since the decision cannot be defended, commencing with the application of state law on a case invoking federal law! Reference to the facility's brief herein are referred as “Br. p.X.”

2. Was the outstanding balance calculated by the facility a valid bill?

The facility claims in its brief that:

> Plaintiff's argument that it is IDHFS rather than Holy Family Villa that determines the amount Slepicka owes for her care from June 1, 2011 through March 3, 2012 (while in a non-Medicaid certified bed) is simply wrong. The Contract controls that period of time. (Br. pp. 18-20).

Plaintiff certainly agrees that the contract is important, but for the facility to state that the Plaintiff's argument is “simply wrong” ignores not only applicable law, but its own contract, which reads:

> Residents covered under the Medicaid Program administered by IDPA must contribute a portion of their income towards the cost of care and Medicaid will pay the balance. The portion the Resident must pay is called Resident Liability. **This amount will be determined at the time of Medicaid approval by the IDPA caseworker.** [1] [¶8(k)] (Emphasis added.)

***2** The facility is extremely cavalier and selective about its own contract. The brief contradicts itself through puzzling statements which attempt to dismiss as null and void Paragraph 8 of its own contract:

> Paragraph 8 simply does not apply here She also agreed that as a private pay resident she will be governed by Paragraph 7; not Paragraph 8 of the Contract. It is only after Slepicka transferred into a Medicaid-certified bed and signed a Medicaid contract that the terms contained in Paragraph 8 controlled.

The facility seems to suggest that only select parts of its contract with the Plaintiff apply - and, perhaps only the facility knows which ones apply. A better view is that *all* terms are legally binding on both parties. Ms. Slepicka complied with the contract to take all steps necessary to apply for and to obtain public **financial** assistance:

> Since HOLY FAMILY will accept public **financial** assistance in lieu of sources of private payment, **Resident and Other Parties agree to take all steps necessary to apply for and to obtain public financial assistance** under any program for which Resident may be eligible. [116(c)] (Emphasis added.)

Ms. Slepicka likewise expects the facility to comply with the contract:

> In the case of an approved Medicaid recipient, **HOLY FAMILY shall not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under the state and federal Medicaid programs, any gift, money,** donation, **or other consideration** as a precondition of admitting (or expediting the admission of) the individual to HOLY FAMILY **or as a requirement for Resident's continued stay** in HOLY FAMILY. [¶8(b)] (Emphasis added.)

It is clear the facility wishes to dismiss paragraph 8 of its own contract so it can charge Ms. Slepicka the much higher private pay daily ***3** rate from June 1, 2011 through March 3, 2012, rather than the lower resident liability amount calculated by the DHS caseworker. The facility cannot just dismiss portions of the contract it does not like. Paragraph 8 of the contract invalidates the "failure to pay" argument as the basis for filing the involuntary discharge proceedings. Thus, ultimately, there was and is no unpaid sum due and no legitimate basis existed to seek Plaintiff's discharge.

3. Availability of Medicaid beds and the Facility's Scheme.

In its brief (p. 21-22) the facility states, "this Court can infer that there were no certified beds available *for Slepicka* until March 4, 2012." Did the facility intend to discriminate [2] against Ms. Slepicka? Why the emphasis *"for Slepicka"* in italics? Were there Medicaid certified beds for other residents, but not for Ms. Slepicka?

The facility argues:

> The only evidence cited by Plaintiff is the testimony of Roberta Magurany ("Magurany"), Holy Family Villa's Administrator. (Br. p.21).

The facility attempts to distance itself from the testimony of its own administrator, as if she did not know what she was testifying about:

Magurany testified that while there were private pay resident(s) in Medicaid-certified beds, she did not "determine whether or **not** a Medicaid bed was available... [between June 1, 2011 and March 4, 2012, into which Mary Slepica [sic] could have been moved." (C.485) (Emphasis in original.)

***4** Again, it appears that the facility intended to discriminate against Mary Slepicka. The facility's Administer stated unequivocally that there were Medicaid certified beds available, but the facility's response brief implies they were *not* for Mary Slepicka. Why not?

The facility selects another provision in its own contract with Ms. Slepicka to ignore, i.e. paragraph 24, which reads in part:

> Room Assignments and Roomates. **HOLY FAMILY shall assign rooms and roommates as needed.** (Emphasis added.)

The facility Administrator stated on record there were at all times *private pay residents in Medicaid certified beds.* (C.485). By contract the facility retains the *exclusive right* to assign rooms to residents. The Court can definitely infer there were in fact Medicaid certified beds available *for Slepicka* before March 4, 2012. It was disingenuous for the facility to state, "[t]hus, there is *no evidence* that a certified bed was available to which Slepicka could have been transferred." The Administrative Law Judge ["ALJ"] did in fact err in finding that "there were no Medicaid Beds available".

With the deftness of a sleight of hand maneuver, the facility argues that "waiting lists" excuse its failure to accommodate Ms. Slepicka:

> Moreover, the evidence is unrefuted that Holy Family Villa was at capacity with a waiting list of 200 individuals. Slepicka, like all others, had to wait her turn for an available bed. (Br. p.21).

This explanation is clearly erroneous. To equate 1) the availability for a person not yet a resident to enter into the facility, with 2) the availability ***5** of a Medicaid certified bed is deceitful. Ms. Slepicka was already a resident of the facility (and under contract) when discussions about her going on Medicaid first took place in the summer of 2011. She did not have to go on a waiting list of 200 to enter the facility again.

The facility acknowledges in its Statement of Facts (Br. p.4) that:

> Mary Slepicka ("Slepicka" or "Plaintiff") applied for admission to Holy Family Villa on February 8, 2011, and was admitted on March 29, 2011. (C.239 and C.190).

It is clear that any waiting list of 200 individuals is a wait list for applicants (non-residents) to be admitted to the facility. (Br. at p.21). The waiting list of 200 individuals is not a waiting list for a Medicaid certified bed. All the testimony of "waiting lists" is suspect. The facility is a 99 bed facility and according to the facility's response brief, "at all relevant times, had a waiting list of approximately 200 individuals." If Ms. Slepicka applied for admission on February 8, 2011, and was admitted on March 29, 2011, **then the facility must have experienced a 200% turnover in its bed availability in 49 days!** Doubtful!

The facility Administrator's testimony was unequivocal: there were private pay residents in Medicaid certified beds at all times. (C.485). Since the facility, by contract, retains the exclusive right to assign rooms for residents, it has no excuse for delaying Ms. Slepicka's transfer the moment it was told she was applying for Medicaid. The Plaintiff had requested the facility to provide such a list at the hearing with the ALJ. (See lengthy discussion at pages 10-14 of the transcript, C.382-386). No ***6** list was provided the ALJ quashed the notice. (C.386). Whether such a waiting list actually exists is again doubtful and unbelievable.

The more likely explanation of why Ms. Slepicka was admitted to the facility just 49 days after she applied was because the facility recognized that if it could get its way, it had a "private pay" for years to come. Its interest was the amount of money it could charge for several years at the private pay daily rate, had she not (as was her right!) sought professional, legal, and **financial** counsel and engaged in prudent estate planning. The facility's scheme to manipulate its bed assignments and concoct

an excuse about waiting lists casts suspicion on its practices. The nursing home bill of rights seems to have little meaning to this facility.

4. Financial exploitation.

The facility hurls considerable and uncharitable invective at the Plaintiff. [“Secretly sequestered all of her assets into a trust to avoid paying for her stay at the facility” (Br. p.6); “**exploited** the law to secretly manipulate her **finances** to qualify for Medicaid” (Br. p.16); “surreptitiously sequestering her assets” (Br. p.17); “secretly manipulated Slepicka's **finances**.” (Br. p.21).]

First, this is pure nonsense and not true - full disclosure was made; there is not even a pretense of a suggestion that anything was withheld from the Department of Human Services, which decides Medicaid eligibility. (See footnote 1 above.)

***7** This continued and feigned offense ought to have been allayed when the Plaintiff's representative procured from the Illinois Department of Human Services an explicit approval of Ms. Slepicka's purchase of her annuity from Western Catholic Union Insurance Company under DHS policy P.M. 07-02-7 [89 Ill. Admin. Code 120.387(e)(13)]. (See C.680).

The actual exchange reads:
From Joseph Oettel, to Mildred Bonds:

I am the Approved Representative for Mary Slepicka. The NH she resides has filed an involuntary discharge against her. One of the issues in the dispute has to do with the retirement annuity. Can you please confirm that the annuity purchased with Western Catholic Insurance was an allowable transfer per DHS policy at PM 07-02-17? [89 III. Admin. Code 120.387(e)(13)]

If you would, please copy Judge Giachello on your reply...

(C.680).

Ms. Bonds replied, copying the administrative law judge and counsel for the facility:
Please be advised, the Western Catholic Union Annuity meet the allowable asset transfer requirements. The policies used to make this determination are PM 07-02-17, PM 07-02-20b and WAG 25-03-12, life expectancy. Based on our calculation, applicant received the market value for this type of purchase and as a result met the allowable asset transfer criteria. This asset is no longer accessible, instead applicant is/will receive a monthly annuity check of $2154.69 until 01/04/17 or date of death.

I hope we were able to clear up any discrepancy that may have existed. If we can be of further assistance, please feel free to contact our offices.

Sincerely Mildred Bonds, HSC Intake Dept. (C.680).

***8** What the facility actually complains about is that it wanted to control how Ms. Slepicka used her assets. After all, the facility (apparently) disregarded its own waiting list of 200 individuals to accelerate the admission of Ms. Slepicka into the facility in just 49 days. It has taken great offense because she acted prudently and hired her own legal counsel, her own Certified **Financial** Planner™ and approved representative, and employed perfectly legitimate means to convert assets to a stream of income to provide for her over her life expectancy.

Use of the inflammatory language in the facility's response brief to attack Ms. Slepicka's prudent estate and **financial** planning certainly raises the suspicion, that perhaps again, the facility seeks to not only ignore the law but its own contract. Paragraph 19 reads:

> Resident's funds. **Resident has the right to manage his or her financial affairs and HOLY FAMILY may not require residents to deposit their personal funds with HOLY FAMILY.** However, if Resident wishes to deposit his or her personal funds with HOLY FAMILY, then HOLY FAMILY will, upon written authorization of the Resident or other authorized person, hold, safeguard, manage and account for such funds. Funds in excess of $50 will be deposited in an interest-bearing account in a federally insured bank or savings and loan association. Funds in such account may be withdrawn by Resident upon written request in accordance with the procedures of HOLY FAMILY. HOLY FAMILY may keep up to $50.00 of the Resident's personal funds in a petty cash fund at HOLY FAMILY to be readily available for the Resident's current expenditures. [¶19] (Emphasis added.)

Given the efforts taken by the facility to direct and manipulate Ms. Slepicka's **finances** we understand its disappointment in failing to succeed, but it was never denied any information it was entitled to. Both ***9** the federal Nursing Home Resident Bill of Rights embedded in federal Medicaid law (42 C.F.R. 483.10), and the State of Illinois guarantee the same rights. 210 ILCS 45/2-102 - 45/2-113. Both plainly state: "you have the right to manage your own **financial** affairs." [42 C.F.R. 483.10(12)(c) and 210 ILCS 45/2-102.)] Another right is to be free from reprisal from the facility in exercising her rights. 42 C.F.R. 483.10(a)(2).

There was no **financial** **exploitation** of Ms. Slepicka by her attorney or **financial** advisors. There was no **financial** **exploitation** of the facility by Ms. Slepicka, her Agent, her attorney, or her **financial** advisors. The facility was well aware of the fact that Ms. Slepicka was interested in applying for Medicaid. In fact, the facility initiated an application process in the summer of 2011. (C.403).

The facility may have felt slighted by "Oettel's refusal to give the facility **financial** information when requested," but the facility had no right to demand such information. By contract and law, Ms. Slepicka has the right to manage her own **financial** affairs. The inflammatory attacks made in the facility's response brief simply heightens the suspicion of its intent to manipulate and control Ms. Slepicka's admission into the facility, to manage her **finances** to the facility's benefit, and to manipulate room assignments for its **financial** gain.

5. Propriety of Medicaid Annuities.

One of the many disturbing misstatements in the facility's brief is the characterization of the Western Catholic Annuity. The annuity is ***10** distinct from a trust agreement. Perhaps the facility simply misunderstands the annuity, however, a copy of the annuity contract was provided to it so its confusion is suspect.

The facility states:
Slepicka **exploited** **the law** to secretly manipulate her **finances** to qualify for Medicaid while retaining her assets.

In order to circumvent the Medicaid resource calculation rules, financial planners devised the "Medicaid Qualifying Trust", which allowed an individual to place his or her assets in a trust to provide for the person's comfort while at the same time creating eligibility for Medicaid. (Emphasis added.) (Br. p. 16).

Ms. Slepicka neither "**exploited** the law" nor set up a Medicaid Qualifying Trust. The attempt is made to equate the annuity to a Medicaid Qualifying Trust, even citing a House committee report. The facility then immediately recognizes, "Congress changed the law in 1988 to outlaw Medicaid Qualifying Trusts." Thus their strawman argument is specious.

Ms. Slepicka purchased a single premium immediate annuity in the amount of $137,000. The annuity will pay her a monthly income of principal and interest in the equal amount of $2,154.69 for 64 months which began in October 2011. These sums go towards her care at the facility. The DHS caseworker, and both federal and state law clearly recognize the purchase of the annuity as an allowable transfer for fair market value and consistent with the purposes and policy of Medicaid.

***11** Had Ms. Slepicka not purchased the annuity she would have exhausted the $137,000 in approximately 22 months. This calculation is done using the private pay rate of $232/day for HFV and Ms. Slepicka's net income in the amount of $755.30. Instead by purchasing the annuity Ms. Slepicka was able to benefit by extending her assets an additional 42 months (her life expectancy was 64 months). This decision was made by Ms. Slepicka on the advice of her attorney and **financial** planner. It is also consistent with the April 10, 2011 contract with the facility:

> Since HOLY FAMILY will accept public **financial** assistance in lieu of sources of private payment, **Resident and Other Parties agree to take all steps necessary to apply for and to obtain public financial assistance** under any program for which Resident may be eligible. [¶6(c)] (Emphasis added.)

A simple math calculation shows that the State of Illinois Medicaid program will save in excess of $71,840 over Ms. Slepicka's life expectancy! Because Ms. Slepicka has the annuity and the monthly income she receives from the annuity goes towards her care at the facility, the State of Illinois Medicaid program is projected to pay $72,139, towards Ms. Slepicka's care at the facility for that same 64 months. This is calculated by taking the difference in the Medicaid rate for the facility in the amount of $137.16/day ($4,114.80/month) and what her net income is including the annuity. (See spreadsheets of monthly Resident Liability at C.678-C.679).

***12** If Ms. Slepicka had not purchased the annuity and would have exhausted the $137,000 in 22 months paying at the higher private pay rate, then Medicaid would have been projected to pay $143,979.36 for the remaining 42 months of her life expectancy. **There is a difference of $71,840 more for the facility at the expense of the State of Illinois.**

In the Statement of Facts the facility's brief states:
In July 2011, Kaminski inquired of Holy Family Villa regarding applying for Medicaid for Slepicka. (C.454). **This is a free service** that Holy Family Villa provides to all residents. (C. 457; C. 495).

Kaminski brought some of Slepicka's **financial** information, and included in the documents was a check for $10,000 that Kaminski wrote to herself out of Slepicka's account. (C. 47; C. 465). **Wojewski told Kaminski that she should void the check because it was an illegal transfer under the Medicaid rules.** (C. 247; C. 465). [Emphasis added]

If the facility could gain an additional $71,840 by manipulating its room assignments and controlling resident **finances**, then of course the facility would like to have full control of handling the resident's Medicaid application. This may be a “free service” to the residents, but comes at a high cost to the State of Illinois and is contrary to the resident's wishes.

Furthermore, it appears the facility is crossing the line into professional areas they are presumably not licensed to be engaging in. When the facility told Mrs. Kaminski to void the check because it was an “illegal transfer under the Medicaid rules,” the facility was incorrect. ***13** Transfers determined to be non-allowable by Medicaid are not “illegal,” they simply create a penalty period from eligibility.

Nowhere in the record does the facility provide any evidence that they are licensed to be in the practice of law, **financial** planning, estate planning, investment advisory services, or insurance. Ms. Slepicka sought legal counsel from her attorney Mike Conroy regarding applying for Medicaid. If the facility is routinely advising residents on legal issues and giving legal advice, which in this case turned out to be incorrect, they perhaps may be engaging in the unauthorized practice of law.

Contrary to the facility's claim, Illinois has not closed this “loophole,” referring to the annuity Ms. Slepicka purchased. In fact, both Congress and Illinois have done just the opposite which has been to expand the use of the annuity instrument as a prudent estate planning tool consistent with the purposes and policy of the Medicaid program.

While the use of single premium immediate annuities have been specifically allowed for decades as an option to convert resources (assets) into an income stream, Congress in 2006 and Illinois in 2012 in fact *expanded* the resource exemption to included Qualified plans, Traditional IRAs, and Roth IRAs as defined in the Internal Revenue Code at sections 408(a), 408(b), 408(k), 408(p), 408(q), and 408A. 42 U.S.C. 1396c(G) and 89 Illinois Adm. Code 120.388(o).

Recent cases substantiate this:
Consistent with the “holistic” approach espoused by the courts in the above cases, and having examined ***14** 42 U.S.C. §1396p(e)(4) in context, I conclude that if Congress had intended to “ring the death knell” for otherwise compliant annuities, it would have said so. It did not. Geston v. Olson (DC ND 2012) 11-CV-044, citing *Weatherbee v. Rickman* (W.D. PA 2009) 595 F.Sipp.2d 607.

It would make little sense for Congress to set up detailed rules and regulations establishing Medicaid compliant annuities and then allow the states, through 42 U.S.C. §1396p(e)(4), to reject Congress's plan. *Geston v. Olson*, 11-CV-044, p.31.

In *Lopes* the court requested the official federal views on Medicaid annuity planning:
Following oral argument, to aid our analysis, we solicited the views of the United States Department of Health and Human Services (“HHS”) regarding “(1) whether the applicable statutes and regulations...require an income stream from an irrevocable annuity to be considered as ‘income’ or as a ‘resource,’ and (2) the policy implications of resolving this case in favor of the plaintiff or the State.” In response, HHS, as amicus curiae, urges us to adopt Lopes‘s, and the District Court's, interpretation of the relevant SSI regulations for two main reasons: (1) the “natural reading of...[§] 416.1201, as clarified in POMS § SI 01110.115, is that [the Social Security Administration] will not require an applicant to renegotiate or, possible, breach a contract in order to recover the value of a resource, such as a non-assignable annuity, in order to qualify for Medicaid’: and (2) **Lopes's retention of the annuity payment stream is not inconsistent with the Medicaid statute's primary purposes,** which are to provide health care for the indigent and protect community spouses from impoverishment while preventing **financially** secure couples from obtaining Medicaid assistance.

(“Congress provided a detailed set of rules governing transactions that it considered suspicious, and the purchase of an annuity is not among them.”) *Lopes v. Starkowski* (2012) 696 F.3d. 180, 2012 WL 4495500, citing *James v. Rickman* (Cir. 3 2008) 547 F.3f 214, 219. (Emphasis added.)

***15 6. The Facility Deliberately Misstates the Applicable Federal Regulation.**

At page 14 the facility rewrites 42 C.F.R. 483.12(a)(2)(v), claiming it states:

> ...for a resident who becomes eligible for Medicaid after admission to a Medicaid certified distinct part of a facility, the Medicaid-certified distinct part of a facility may charge a resident only allowable charges under Medicaid.

That is NOT what that section says and the facility blatantly misrepresents the “second sentence” of Section 483.12(a)(2)(v), which actually reads:

> ...for a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge only allowable charges under Medicaid.

To bolster that distortion the facility seeks to distort the definition of "facility" contained in the federal regulations, to wit: 42 C.F.R. 483.5(a). The *outrageous* claim is made that "facility" refers only to "that distinct part that participates in the applicable federal program - here, Medicaid." Strange exegesis!

One need only give the cited language its plain meaning. The facility highlights the following sentence in the regulation: "Facility' may include a distinct part of an institution." It would have the court read it to say "facility" is only the "distinct part." Instead it plainly says a "facility" may *include* a distinct part. Of course, just as here - the facility - *includes* a distinct part.

***16** The other language highlighted from 42 C.F.R. 483.5 likewise does not support the facility's argument; it says, the "facility" is always the *entity* that participates in the program *whether comprised of all or a part.* Allegedly to provide needed gloss on its interpretation the facility cites *Schoolcraft Mem. Hosp. v. Mich. Depty of Cmty Health* (W.D. Mich 2008) 570 F.Supp.2d 949. That case pulls down the walls the facility has built around its distortion. One need only read footnote number 3. It says, "'the TRR [transfer-restriction regulation] applies to facility[ies].' 42 C.F.R. § 483.12. A facility is an SNF or NF. 42 C.F.R. § 483.5." The opinion at 570 F.Supp.2d, p.954 could not be more specific: "SNFs and NFs are, essentially, nursing homes, and the TRR applies only to them." Thus *Schoolcraft* is of no help to the facility. It destroys the facility's own argument.

7. Does the "bed certification" Letter Trump Ms. Slepicka's Specific Approval for Medicaid.

The facility attempts to elevate the *general* letter to the facility on April 22, 2009 certifying certain beds, above the *specific* Medicaid approval notices for Ms. Slepicka dated February 17, 2012 and July 6, 2012. The contract between the facility and Ms. Slepicka reads

In the case of an approved Medicaid recipient, **HOLY FAMILY shall not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under the state and federal Medicaid programs, any gift, money,** donation, or **other consideration** as a precondition of admitting (or expediting the admission of) the individual to HOLY FAMILY or as a requirement for Resident's continued stay in HOLY FAMILY. [¶8(b)] (Emphasis added.)

***17** Residents covered under the Medicaid Program administered by IDPA must contribute a portion of their income towards the cost of care, and Medicaid will pay the balance. The portion the Resident must pay is called Resident Liability. **This amount will be determined at the time of Medicaid approval by the IDPA caseworker.** [¶8(k)] (Emphasis added.)

Clearly DHS's specific Medicaid approval for Ms. Slepicka is not trumped by the 2009 "certification letter." Her approvals from the caseworker are controlling and the facility is bound by law and by contract. All attempts by the facility to dismiss the Medicaid approval notices are in breach of contract and contrary to 42 C.F.R. 483.12.

8. Subject Matter Jurisdiction.

The further claim is made that this court lacks subject matter jurisdiction to hear this appeal. This argument is actually about venue. This issue was raised before the circuit court (C.116) and denied. (d/e 9/24/2012.) *No cross-appeal was filed.* Thus the matter is not before the court on this appeal.

The facility is, in any event, exceedingly grudging in its interpretation of "jurisdiction and venue" under the administrative review law. 735 ILCS 5/3-104. That section reads:

> Jurisdiction and venue. **Jurisdiction to review final administrative decisions is vested in the Circuit Courts,** except as to a final order of the Illinois Educational Labor Relations Board in which case jurisdiction to review a final order is vested in the Appellate Court of a judicial district in which the Board maintains an office. If the venue of the action to review a final administrative decision is expressly prescribed in the particular statute under authority of which ***18** the decision was made, such venue shall control, but if the venue is not so prescribed, an action to review a final administrative decision may be commenced in the Circuit Court of any county in which (1) any part of the hearing or proceeding culminating in the decision of the administrative agency was held, or (2) any part of the subject matter involved is situated, or (3) any part of the transaction which gave rise to the proceedings before the agency occurred. The court first acquiring jurisdiction of any action to review a final administrative decision shall have and retain jurisdiction of the action until final disposition of the action. (Emphasis added.)

Since jurisdiction is "vested in the Circuit Courts..." the suggestion that the circuit court lacked subject matter jurisdiction is completely spurious.

Venue "may be commenced in the circuit court of any county in which any part of the hearing or proceeding culminating in the decision of the administrative agency was held," etc. The facility acknowledges that the Department of Public Health has offices in Springfield. (Facility Br. pp 27-28). It is clear that the decision, made by the Assistant Director on delegation of the Director, emanated from Springfield. (C.007). There is no evidence that the decision was made or effected anywhere else as the facility would have the court speculate.

The facility selectively quoted the trial court, but omitted his statements, "I have to give the statute its ordinary, plain meaning when I read it...the action is properly brought here...there is no *forum non conveniens.*" (Record Vol. V, p. 17). The authority under consideration by the court was this court's decision in *Midland Coal Co. v. Knox County* (1994) 268 Ill.App.3d 485, 206 Ill.Dec. 28, 644 N.E.2d 796. The doctrine ***19** of "*forum non conveniens* does not apply to administrative review action brought in circuit court." 258 Ill.App.3d @ 489. The principal reason is that the circuit court "sits in an appellate posture and makes its decision on the record from the administrative proceedings." 268 Ill.App.3d @ 488.

As noted, and even assuming any credence could be given this argument, no cross-appeal was filed and therefore, the issue was not preserved on the appeal to this court.

9. The Appeal is not Moot.

A claim is made that this appeal is moot - it is not. A motion was previously filed in this court by the facility to dismiss the appeal as moot which was denied. No rehearing was sought on that denial, nor did the order denying it reserve any part of the claim as "taken with the case." We include in an appendix to this brief the previous order of this court denying the motion to dismiss the appeal as moot. Moreover the motion misstated the facts - most of the funds paid were paid under a strong protest and by a third party, including an express reservation on behalf of both the Plaintiff and the third party to recover these said monies. (See Response to Motion to Dismiss Appeal as Moot, for convenience included in the Appendix to this brief, including the affidavit and exhibit attached thereto.)

***20 10. Elder Law Journal Article.**

The facility dismisses the **Elder** Law Journal article cited by the Plaintiff as "nothing more than an advocacy piece," whatever that means. We assume the facility intended its entire brief as an "advocacy piece." Denigrate the article all you want, at a minimum it points out the pervasiveness of the problem and the crying need to address the issues. This case presents the opportunity.

CONCLUSION

Plaintiff-Appellant prays the court reverse the trial court, enter judgment for the plaintiff on all issues and remand for an adjustment of Plaintiff's account in accord with the Medicaid determination, and an award of fees in favor of the Plaintiff-Appellant and against the Defendant-Appellee.

Footnotes

1 To clear up a little confusion, the Department of Human Services [“DHS”] was formerly known as the Illinois Department of Public Aid [“IDPA”]. The DHS intake caseworker determined Ms. Slepicka's monthly Resident Liability. Several years ago IDPA split into two agencies - 1. DHS, and 2. The Illinois Department of Healthcare and Family Services [“IDHFS”]. The response brief errors in stating Plaintiff argued IDHFS determined the amount Slepicka owes. Plaintiffs brief makes no such assertion, but correctly states DHS determines the amount owed. (See Medicaid decisions in the record at C.24, 308, 651, 656, 664).

2 42 C.F.R. 483.12(e); the facility acknowledges that it “cannot treat Slepicka differently, or give her preferential treatment just because she is seeking Medicaid benefits.” (Br. p.18).

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